BONELA

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Lessons Learned

Challenging structural barriers through the Gender and Sexual Minority Rights Coalition in Gaborone (Botswana)

SUMMARY

The activity Bonela focused its Lesson Learnt Document on is the Gender and Sexual Minorities Coalition which operates in Gaborone and surrounding areas in Botswana. Convened together with Lesbians, Gays and Bisexuals of Botswana (LEGABIBO), the coalition aims to challenge structural barriers, like law and religion, to health and wellbeing that most at risk populations (MARPs) face at multiple levels in Botswana. The target was to enable greater impact advocating for change through collaborative efforts amongst its member organisations. Since it was first conceptualised in 2011, the coalition has collaborated on spaces for support groups, court cases, world awareness days, training, documentation, and funding. This Lessons Learnt document looked at the current state of the coalition, including successes, challenges and ways forward.

DESCRIPTION OF ACTIVITY

A MARPS coalition called the Sexual and Gender Minority Rights Coalition, was formed to influence national programming to include most at risk populations in the national HIV response. This is done both through advocacy work at community service and government level, as well as by coordinating and supporting key population led programming.

Over the past four years, with the support of COC and under the banner of Proudly Combined, Bonela and LEGABIBO convened a coalition of 10[1] organisations that work with key populations (LGBTI, MSM, WSW, sex workers, prisoners). The coalition, which is an initiative not an organisation, seeks to achieve its vision through bringing together stakeholders from the community to collectively advocate for access to HIV prevention services for sexual and gender minorities. This Lessons Learnt document focuses on what organisations have learnt developing and implementing the coalition, including successes, challenges and ways forward.

The Coalition consists of the following activities:

- Public education and awareness
- Capacity building for coalition members
- Advocating for a rights based approach to service delivery
- Efficient and strategic communication
- Sensitise local authorities and service providers
- Engaging service providers
- Lobby key stakeholders including parliamentarians

Botswana is applauded for much success in the national response to HIV/AIDS. This is due to the scaling up of Prevention from Mother to Child Transmission programme, which currently has a success rate of 95%, and the roll out of free anti-retroviral drugs, with a successful coverage of 96.1%. Despite these successes, many challenges and gaps persist, thwarting efforts to effectively and comprehensively address the epidemic.

One of the major challenges is exclusion of key populations such as sex worker, lesbian, gay, bisexuals, transgender and inter-sex communities, men who have sex with men (MSM) and women who have sex with women (WSM) from HIV programming. Access to HIV services for marginalized populations is further jeopardised by a lack of an enabling legal, cultural, and religious environment and the subsequent lack of legal protection for most at risk populations.

Against this background, civil society organisations in Botswana formed a coalition to advocate for access to targeted services for sexual and gender minorities. The coalition's objectives have included: Develop a Terms of Reference, a collective agenda and hold regular coalition meetings; capacitate coalition members through inter-organisational sharing/training in understanding sexual and gender minority issues and make sure this knowledge trickles down to constituents; provide access to justice for LGBTIs through legal aid; collaborative advocacy for access to services for the LGBTI community (through identifying and providing evidence for what should be included in an HIV response minimum service package like lubricant); and lobby policy makers and legislators to enact policies and laws that facilitate integration of LGBTI services. In the past, various civil society organisations have advocated for access to HIV prevention services for key populations. However, these efforts have been fragmented and as such minimal impact has been created to date.

Through the coalition, civil society organisations intended to work jointly and coherently to advocate for access to HIV prevention services for sexual and gender minorities.

The coalition was first conceptualised in 2011 and implementation was planned from 2012 to 2015 (activities are currently ongoing). Within the context of HIV programming, the coalition specifically targets sex worker, lesbian, gay, bisexual, transgender and inter-sex communities, men who have sex with men (MSM), women who have sex with women (WSW) and prisoners/ex-prisoners. It operates at multiple levels including civil society (engaging with a collective of NGOs), grassroots (working within communities), and policy (facilitating high level engagement with the National AIDS Council and the Parliamentary Committee on Health). Between all the member organisations, the coalition targets people aged between 18-40 years in Gaborone, Francistown, Maun, Mahalapye, Palapye, Serowe, Mochudi and Selibe Phikwe within Botswana.

This coalition was part of the Proudly Combined Program formed in response to multiple cultural, religious, political, and legal structural barriers on the premise that as a collective, the coalition is more able to challenge barriers. Activities of the coalition over 2011 – 2014 have included psychosocial services, outreach, training/capacitating, referral to sensitised nurses and social workers, generation and distribution of IEC and commodities, quarterly coalition meetings, collaboration on awareness raising events (IDAHO, World Aids Day, Sex Worker Rights Day), and legal aid on intimate partner violence, sexual assault, access to gender re-assignment surgery, and inheritance cases.

To discover and tease out key factors for successes and failures of the coalition and ways forward, Bonela contracted an independent consultant to conduct individual interviews with various coalition stakeholders. This group of 7 respondents consisted of 3 peer educators/support group facilitators (2 from LGBTI support groups, 1 from an HIV support group), 2 programme coordinators/officers, and 2 directors based in Gaborone and Mochudi, and whose activities are implemented in 8 different areas in Botswana targeting MSM, WSW, LGBTI, and sex workers.

Interviewees were asked questions about implementation (please see sections B, C and D of this document).

The individual interviews, which highlighted honesty and a climate of non-judgement, allowed for multiple voices to inform the lesson learnt process.

IMPLEMENTATION AND ACHIEVEMENTS

Steps have included:

a. Draw up a coalition plan (Terms of reference).

b. Garner interest, support and buy-in from organisations who have some level of interest/involvement in access to services for MARPs and cultural issues hindering their constituents.

c. Appoint conveners (Bonela and LEGABIBO) responsible for managing the relationships and maintaining consistent communication with coalition members, developing policy position papers and statements through consultation with members and other stakeholders, organising events, seminars, workshops and meetings (IDAHO, Sex Workers Rights Day, LILO training, HIV and LGBTI support spaces), communicating the status of the campaign to members (coalition meeting reports), co-coordinating and facilitating meetings between coalition members and external stakeholders (government officials), support coalition members in understanding MARPs, gender minority issues and the broader policy environment.

d. Hold quarterly coalition meetings to determine annual objectives and priorities and to approve advocacy strategies.

e. Where necessary, letters are written to coalition members and phone calls made to get quotations for venues. These are compared, a cheque requisition is raised and then submitted to Finance department internally. Based on the lowest quote, Finance books the venue through a purchase order while preparing a cheque.

f. Programme officer and peer educators confirm attendance and raise requisitions for transport reimbursements depending on the type of participants. An agenda is drawn and followed on the day of the activity. The event is then evaluated or way forward agreed upon.

- **What was the strategy or chosen approach?**

To involve members of the coalition in advocating for greater health access as a collective.

- **Describe how you thought this strategy would contribute to solving the problem. What was your line of thinking, what was your 'theory of change' and were your operational assumptions?**

It had become increasingly clear that advocating in insolation for health services for gender and sexual minority is ineffective. The assumption was greater success could be achieved if organisations in the sector collaborated, giving issues a louder voice and human face.

- **What were the essential resources needed for implementation of the activity? (financial, material, human resources, specific competencies or knowledge)**

a. *Financial resources:*

Funding was secured through COC and Aids Fonds to cover the cost of venues, reimbursements and activities.

b. *Human resources:*

Needed personnel/staff who were good at managing a diverse group of personalities and organisations. Personnel to carry out coalition activities were secured through partnerships within the coalition (project officers, peer educators, nurses and social workers).

c. *Competencies and knowledge:*

Peer educators and health care providers needed an understanding (sensitisation) of addressing the specific needs of sexual and gender minorities.

- **Was the activity adapted over time? Were measures and solutions taken to overcome previous difficulties and challenges?**

a. The name of the coalition was adjusted from "Sexual Minorities Coalition" to "Gender and Sexual Minority Rights Coalition" to include identities that do not fall under the sexual minority category (such as trans* and intersex individuals, as well as current and past prisoners). This issue was raised at a meeting by those involved with gender identity (trans*, intersex and prisoners) and behavioural risk, rather than sexual orientation.

b. Annual priorities were adjusted according to input from the coalition, members were encouraged to attend meetings and to submit documents on ongoing activities for coordination purposes. Adjustments to prioritised activities were communicated in reports.

- **What were the major turning points in the process? These are the most significant changes taking place during the chosen period of time which had a direct influence on the activity.**

The most significant shifts in this process were:

a. Resignations and new appointments within the convening and steering committee, support groups and within government (national elections) disrupted ongoing activities, processes, and relationship building, and created knowledge gaps.

b. There was a loss of momentum stemming from a lack of clarity and communication between conveners and organisations on objectives, expectations, leadership and feedback.

c. Training and capacitating member organisations was an important shift as people felt more able to attend to tasks.

d. Winning legal cases has been validating and motivating. These cases included a rape case (plaintiff was in a relationship with the defendant) and a case challenging access to health services for a transman (plaintiff was denied access to a hysterectomy when referred from private to public health care).

e. There has been a positive shift in government mind set regarding the importance of including key populations in the national HIV response, especially since the national Integrated Biological and Behavioural Surveillance Study (through collective advocacy MARPs were included in the study).

f. Funding from LEGABIBO to peer educators for refreshments and airtime never transpired or were very irregular so one of the support groups filled the gap by asking for donations from its members. This allowed the groups to continue.

- **What were the major internal and external factors which shaped the development of the activity?**

Problematic internal factors that have shaped the coalition include new staff appointments in the coalition and a lack of internal communication. Some beneficial internal factors have included the commitment and passion of stakeholders/officers to their work, greater access to the expertise and assistance of long-standing organisations within the coalition, and capacitating officers (through trainings).

Externally, there has been a positive shift over the last 2 – 3 years in the socio-political environment and a demand amongst key population communities for services which has enabled more open dialogue about most at risk populations at grassroots and policy level. However, there is still a lack of a conducive legal environment that can facilitate effective service delivery. A lack of financial support for intended activities has also shaped outcomes.

WHAT WERE THE RESULTS?

Outputs:

a. Commitment of coalition members to the coalition and its agenda.

b. Access to justice for the LGBTI community through provision of legal aid (7 cases so far).

c. Awareness raising on MSM and health issues as a coalition through a fact sheet (1,200 sheets produced and distributed).

d. Capacitating the LGBTI community (100 members) on health and legal issues.

e. Collaboration on awareness raising activities (marches/events on IDAHO, World Aids Day, and International Sex Workers Rights Day)

f. Distribution of over 200 safer sex packs to support group members (supplied by LEGABIBO).

g. Provision of support group spaces (6 stable groups with on average 10 – 20 LGBTIs, MSM, and allies).

h. Advocating for the provision of lubricants as part of the STI/HIV prevention package by lobbying the Ministry of Health and through utilisation of the media.

Outcomes:

a. Have not yet succeeded in securing lubricant (by specifically distributing lube with condoms) access in Botswana with the Ministry of Health. An initial meeting was held with government, but there has subsequently been an election, meaning those present at the time have moved and no efforts have been made yet to re-establish the dialogue (the Ministry of Health has contacted the Central Medical Store to place an order for lube, however the Store is refusing to fill the order.

b. Sisonke has succeeded in securing funding with coalition support. The LGBTI support groups report that there was an unexpected demand for community level activities from the friends and family of LGBTIs who sometimes attend groups/approach group facilitators. Parents, friends and family of LGBTIs requested to join the group which provided a sense of validation and a "job well done"

c. Some support group members attend just to get access to the safer sex packs, particularly the lubricant, which is not available elsewhere for free.

d. The HIV support group reports no structural barriers as they refer to hospitals and no one as yet, has reported stigma or discrimination.

- **Were there any unexpected results? If so, which?**

The provision of legal aid to the LGBTI community went beyond health to cover rape and inheritance cases. The support groups were surprised that allies, friends, and family of LGBTIs requested activities they could attend.

- **Which results or targets were not reached?**

a. Getting audience with the Ministry of Labour and Home Affairs to discuss gender identification on national identity documents as well as the total change in structural barriers (such as religion)

b. Final confirmation on mainstreaming and distribution of lubricant through government.

c. Some activities did not transpire due to a lack of funding.

- What were the main difficulties faced?

a. The momentum of the coalition slowed down and the spirit of co-ownership eroded due to a lack of communication and clarity on coalition objectives, difficulties accessing people responsible for activities/departments, and new staff appointments within the coalition and government which created gaps in implementation and engagement at high and grassroots levels.

b. In some instances, there was not enough alignment between activities prioritised by the coalition and an individual organisation's mandate, resulting in difficulties coordinating time, energy, and interest.

c. Within the support group spaces, a major challenge has been a lack of consistent funding/refunds for airtime, transport, refreshments, and growing activities to include larger events for allies, family and friends. There is also a lack of IEC and commodities for outreach (uniforms, name tags, umbrellas, IEC, safer sex packs) and a need for refresher trainings and trainings. Transport, distance, confidentiality, a person's own level of self-acceptance and fear of being outed have impacted attendance.

d. Currently, the nurse provided through the Botswana Association of Social Workers and BOFWA partnership only comes at certain times to the MSM safe space (at Health for Men and Gender Justice) which is insufficient for clients accessing the service.

ANALYSIS AND LESSONS LEARNED

The coalition has worked to a great extent as intended: Structural barriers in law and health are being addressed through combined efforts amongst coalition partners.

Actual practice has followed the theory of change - as a collective it has been more possible to have greater impact in advocating for access to health and policy reform. For example, in September 2012, BONELA and the coalition on Gender and Sexual Minority Rights held a meeting with the director of HIV/AIDS prevention, in the Ministry of Health to raise awareness among policy makers at ministerial level and implementers about the need to include water based lubrication in the national prevention package. The meeting resolved that the coalition should produce evidence to support a proposal presented to the national HIV/AIDS Council in 2013. Another success has been collectively advocating for inclusion of MSM and sex workers in the Behavioural and Biological Survellaince Survey study findings as carried out by the Ministry on key populations.

However, there may be problems with some operational assumptions which if adjusted would allow the coalition to be more successful and sustainable. For example, in the Terms of Reference, the underlying principles (meaningful participation, mutual trust, mutual ownership of process) as well as convener responsibilities (including managing relationships within the coalition and maintaining consistent communication with members) and coalition responsibilities (including approving advocacy strategy and providing technical support to conveners) are detailed. It may prove beneficial to re-visit and expand on how this will be achieved.

Factors for success of the coalition include: (i) regular, well attended coalition meetings (ii) open dialogue and an atmosphere of friendly critique (iii) trust, communication, consistency and active participation amongst coalition leadership and members (iv) a spirit of volunteerism and eagerness to attend to tasks (v) effective engagement and relationship building with health care service providers.

Factors for failure include (i) a lack of/break downs in internal communication and trust (ii) a loss of momentum and energy (iii) conflicts and confusion around priorities (iv) changes in staff appointments with insufficient handover and (iv) a lack of/unreliable funding from LEGABIBO to peer educators/focal persons to grow activities.

During the interviews, coalition members reported the following lessons:

- **Working together does not necessarily mean having the same interests.** There is a need to distribute activities in a way that is more relevant, meaningful and important to organisations. When coalition priorities conflict with the daily goals of an organisation the workload becomes overwhelming, energy/interest are depleted and the spirit of

co-ownership suffers. Almost all respondents reported feeling frustrated over a lack of consistent internal communication amongst conveners and organisations. **Break downs in internal communication processes within the coalition have been disruptive and prohibitive to sustainability.**

- New staff appointments, unavailable/ unapproachable lead persons, inconsistent representation at coalition meetings, and insufficient and irregular meetings has resulted in confusion about the purpose, expectations and status of the coalition, and what is expected of member organisations for 2015. A major lesson has been that **for the coalition to work, there needs to be channels for constant communication which allow on-going adjustments and group input to be easily communicated to the whole coalition.**
- Respondents learnt that time sensitive funding and refunds can be unreliable which has impacted planning and implementation. They identified a need for **alternative options to mobilise funding/ resources separately from the coalition, or ways to manage funds on their own/directly.**
- Peer educators/facilitators report they have learnt about themselves, patience, balancing multiple personalities, dealing with impromptu issues, fostering trust and group communication, and creating context-specific environments. An important factor for success has been the spirit of volunteerism and mutual support amongst support group members. **Training provided by LEGABIBO and LILO's[2] focus on leadership have proven very useful and interesting. However, knowledge and skills leave when peer educators/facilitators move on and there is a need to plan for these inevitable gaps by providing training for promising/ passionate members of existing support groups.**
- All the peer educators/facilitators report that there is a **need and demand for targeted psychosocial interventions at the community level.** Ignorance and stigma amongst family members and friends of target populations remains a structural barrier to self-acceptance which reduces a person's likelihood of accessing available services and rights. Further, the HIV support group reports a need to create entrepreneurial activities for their members (such as bead making) to address unemployment and poverty as structural barriers.
- Peer educators would rather distribute commodities themselves as they report some people are too shy or afraid to access safer sex packs from clinics/ organisations.

The coalition learnt it would do the following differently:

- Revisit and review the objectives and concept note of the coalition and make relevant adjustments.
- **Meet as a coalition more regularly** (2 -3 times a quarter).
- **Reflect on and identify where the coalition is currently,** what has happened so far, and then plan future activities based on the emergent data.
- Appoint **an independent and objective body** who does not have potentially conflicting interests to do oversight/convening that will be able to help shape and guide the refinement of the coalition's mandate. A few respondents reported they feel the collective agenda is guided by the vested interests of the current convening organisations (Bonela and LEGABIBO) and an objective convener/consultant (not linked to any of the coalition partners) may prove useful in fostering co-ownership.
- Open a Google/Facebook Page to keep in touch consistently and prioritise effective planning and communication on activities.
- **Tackle issues beyond but related to HIV prevention and key populations such as alcohol abuse, intimate partner violence, land disputes, utilities, employment, bullying on campuses, and discrimination.**
- Extend the coalition and **invite other organisations with an interest in addressing structural barriers.** Find more contributors and involve other stakeholders in awareness raising and advocacy for change (such as development partners and embassies).
- Design self-financed or funding alternatives for venue spaces, refreshments and creative/ entrepreneurial activities for support groups. Alternatively, the coalition could take on more of a funder role and provide effective financial support for activities and provide assistance in applying for timeous funds and re-funds.

- Plan and implement more outreach activities within communities to drive membership and raise awareness of available services and rights. For instance, peer educators would like to collect and distribute LEGABIBO's safer sex packs in the community where stigma is pervasive and because some people cannot afford transport to existing support groups.
- **Make training spots available for support group members who may in future be interested in being peer educators/focal persons so there are already trained replacements if facilitators leave.**
- Make a full time nurse and social worker available at the Health for Men and Gender Justice safe space for MSM to access.

WAY FORWARD

- **Look at the consequences to applying these learnings. What will happen when you apply this learning?**

The coalition would like to foster more regular and effective communication, coordination and planning of coalition activities and have a greater understanding of the efficacy of engaging more stakeholders. An intended output is the sustainability of the coalition and greater success in making relevant service provision accessible to gender and sexual minorities in Botswana.

- **Do you identify any blocks that may occur to stop you applying the learning?**

Some blocks may include defensiveness in response to critical open dialogue about uncomfortable issues, a lack of commitment to drive processes, and as well as a lack of co-ownership. The hostile cultural environment and pervasive stigma also continues to be a block to community level interventions. A lack of/inconsistent funding and refunds for transportation, airtime and venues may prohibit the growth of outreach activities within and beyond current hot spots.

- **Clarify your first steps in applying the new learning. What will you do next?**

a. Have a meeting with the coordinators of the coalition and all coalition representatives to clarify where the coalition currently stands and to share the lessons learnt document.

b. Make time to regularly re-look at the basics such as the coalition mandate.

c. Garner buy in for a coalition Facebook Page and ask IT to assist in developing an interesting page.

d. Find a balance between individual member obligations and coalition objectives.

e. Create direct connections and relationships with donors, funders, and lead persons to generate more opportunities for communication, sharing of expertise, and coordination of assistance.

f. Ask support group members to draw on their networks and bring two allies/friends to grow the groups and to start accessing the broader community.

g. Host group dialogues within support groups/outreach activities with a human sexuality expert explaining what LGBTI is.

h. Enable peer educators to collect available commodities from LEGABIBO, and other organisations with available commodities, for distribution in hot spots.

ADDITIONAL DOCUMENTS

- Coalition Meeting Report, 10 August 2012
- Proudly Combined Narrative Report, 2013
- Coalition Meeting Report, 22 May 2014
- Terms of Reference Sexual and Gender Minority Right Coalition with SLR input, 14 August 2012

ORGANISATIONAL BACKGROUND:

The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) is a non-government organisation committed to integrating an ethical, legal and human rights approach into Botswana's response to the HIV/AIDS epidemic. BONELA is a network of concerned individuals, groups and organisations interested in protecting and promoting the rights of people infected with and affected by HIV/AIDS.

Members include individuals from the legal community, community-based organisations, public and private sectors, academics, concerned individuals and people living with HIV/AIDS. BONELA was launched as a component of the Shared Rights, Shared Responsibilities Project in September 1995 and registered under the Societies Act in early 2002. The organisation has grown significantly since then, employing 7 full-time employees who carry out its daily work and actively raise funds to fulfil its mandate in Botswana. BONELA is governed by a Board elected every two years and reflects a range of professional experience. With a non-profit mandate, BONELA primarily receives financial assistance from local and international donor organisations but also raises funds through the sale of publications, other activities, and the support of individuals and members.

Vision of the organisation:

Making human rights a reality in the response to the HIV and AIDS epidemic in Botswana.

Mission of the organisation:

Bonela is a network of individuals and organisations that promotes a just and inclusive environment to prevent HIV infection and provide a greater quality of life for people affected by HIV and AIDS through scaling up a coordinated community response and promoting accountability.

FOOTNOTES

1. LEGABIBO (Lesbians, Gays and Bisexuals of Botswana), Sisonke Botswana, Nkaikela Youth Group, BONELA, Rainbow Identity Association, BIRRO (Botswana Institute of Rehabilitation and Integration Organisation), Pilot Mathambo Centre for Men's Health, Men for Health and Gender Justice Organisation, BONEPWA (Botswana Network of People Living with Aids), Research Triangle Institute (RTI) (no longer a member).

2. LILO, a Positive Vibes product, stands for "Looking In, Looking Out" and is a facilitated process to support LGBTIs to reflect on their lives, to develop a positive LGBTI identity, and to enable collective action through nurturing self-esteem so LGBTIs feel they deserve to advocate for and claim their own rights.

Lessons Learned publications in this series:

32. Moving beyond individual counselling of LGBTI people to address central psychosocial issues on community level in Tshwane (Pretoria)
31. Bonela Challenging structural barriers through the Gender and Sexual Minority Rights Coalition in Gaborone (Botswana)
30. CEDEP Advocacy Approaches in Malawi
29. GALZ Lessons learnt amongst MSM in the uptake of Male Circumcision (Zimbabwe)
28. Uptake of Post-Exposure Prophylaxis (PEP) by Men who have Sex with Men in Tshwane (Pretoria).
27. OUT's Peer Education Programme for MSM / LGBT's in Tshwane, Pretoria
26. The Pink Ballot Agreement
25. Peer Education Programme (Malawi)
24. Schorer Monitor
23. Health, culture and network:Interventions withhomosexuals living with HIV/AIDS at Rio de Janeiro polyclinics
22. Telling a story about sex, advocating for prevention activities – informational materials about safe sex and harm reduction for gay men and MSM from 14 to 24 years.
21. Mainstreaming of LGBTI/MSM/WSW issues in all areas of service provision: Empowering Service Providers and Policy Makers in Botswana through trainings
20. Now we are talking! – Developing skills and facing challenges.
19. Towards a Comprehensive Health Care Service Model for Transgender People in Ecuador
18. Comparative analysis and account of the outreach process to implement a method to change behaviors of youngsters with homo/lesbo erotic feelings in Costa Rica
17. Methodology for behavioral change in teenagers with same sex feelings, from the Greater Metropolitan Area, in Costa Rica
16. Breeding Ideas: building up a young peer educators' network.
15. Prevention Images: notes about a photography workshop with young MSM and people living with HIV/AIDS in Rio de Janeiro
14. Advocacy campaign to prohibit hate lyrics targeted at men having sex with men during a dance hall concert in Suriname.
13. Interactions between young multipliers and young gays and bisexuals in internal and external activities in Rio de Janeiro (Brazil).
12. Information Stands: Prevention Project aimed at young gay men from Tegucigalpa (Honduras)
11. Ndim'lo (This is me) Photovoice with lesbian and bisexualwomen in the Western Cape, South Africa
10. Me&3 Campaign for lesbian and gay individuals in Pretoria (South Africa)
9. Sensitization of the National Policeby transgender organizations in Ecuador
8. Exercising 'Knowledges': Implementing training and prevention activities.
7. Public Incidence Activities: In search of public spaces accessible to teenagers with same sex feelings in the Greater Metropolitan area of Costa Rica. "Specific Case: Incidence with the National Institute for Women - INAMU - Costa Rica"
6. My body, your body, our sex: A Sexual Health Needs Assessment For Lesbians and Women Who Have Sex With Women, Durban, South Africa
5. Working with buddy groups in Zimbabwe
4. 'MAN TO MAN', a joint approach on sexual health of MSM in the Netherlands via the Internet
3. Lessons learned from project "Visual information on sexual health and the exercise of citizenship by the GLBTI beneficiaries of the Organization in Quito, Ecuador".
2. Coffee afternoons: Prevention Project aimed at young gay men from Tegucigalpa (Honduras)
1. Womyn2Womyn (W2W) quarterly open day, for lesbian and bisexual (LB) women at the Prism Lifestyle Centre in Hatfield, Pretoria (South Africa)

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